Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

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Special points of interest:

- You may be required to provide specialized rehabilitative services for your residents.
- Current insulin storage and stability information.
- RAI update of August 2003.

Specialized Rehabilitation Services

By Kara Steier, LSW

A recent decision by the First Circuit Court of Appeals established the right to services for people with mental disabilities in nursing homes. In Rolland v. Romney the ruling requires that nursing home residents with mental retardation or other developmental disabilities receive "specialized services" when needed. The decision is the first court of appeals case to "establish the rights of individuals with mental disabilities to specialized services in nursing facilities," according to the Brazelon Center for Mental Health Law.

Though the above court case doesn't address regulations that are specifically surveyed, it does address an issue that is discussed in the federal regulations for long term care facilities. The following information concerns the regulation of specialized rehabilitative services (F406), the regulation that is specifically surveyed for and does relate to the regulation cited in Rolland v. Romney.

The regulation of specialized rehabilitative services states: "If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness [MI] and mental retardation [MR] are required in the resident's comprehensive plan of care, the facility must provide the required services or obtain the required services from an outside resource from a provider of specialized rehabilitative services."

The part of the above regulation that ties into Rolland v. Romney is "mental health rehabilitative services for mental illness and mental retardation." which refers to those services implemented by ALL levels of

(cont. on page 2)

Specialized Rehabilitation Services (cont.)

nursing facility staff who come into contact with the resident who is mentally ill or has mental retardation.

The areas of the MDS that should trigger a more thorough look into rehabilitative services specifically for people with mental illness and mental retardation are Section E, "Mood and Behavior Patterns" and Section F, "Psychosocial Well Being." If these sections are coded, be sure to address the areas of need on the resident's comprehensive plan of care. The following questions should be asked as you address these areas: What has been done to decrease incidents of inappropriate behaviors for individuals with MR, or behavior symptoms for persons with MI? What has been done to increase appropriate behaviors? How has the facility modified the training strategies it uses to address the special learning needs of its residents with MI or MR?

With those questions in mind, it may be a good idea to look at developing a behavior plan. It is not a requirement to have a separate behavior plan; however, if behaviors/behavior symptoms are an issue for any resident with MI or MR, it is the facility's responsibility to address the issue in the resident's care plan.

Something to keep in mind is that behavior is almost always communicating something. You, as caregivers, need to figure out what the resident is trying to communicate. Some areas to consider when assessing a person's behavior are antecedents to the behavior; consequences of the behavior (both positive and negative); reinforcements (both positive and negative); physical, mental or psychiatric conditions that may be present; and medications the resident is taking. Don't forget to consider the physical environment. Attempt to determine if the behavior is a signal for something such as the presence of pain or discomfort, the desire for a preferred item, person or setting, or perhaps the escape from a nonpreferred item, person or setting.

After an assessment of the behaviors is complete (although assessment is never truly done), it is time to develop behavioral approaches specific for the resident. Is there a time and/or place in which the behavior is more likely to occur? Would a change in the environment or the resident's routine reduce the probability of the problem behavior? If so, be sure to address these in the resident's care plan. Something else to address is that it is not only important to decrease the problem behavior, it is EQUALLY important to teach the resident appropriate responses to replace the problem behavior. Remember, if a resident is using a behavior to communicate, than finding an appropriate way to communicate that desire is critical in removal of the problem behavior.

REFERENCES

Vranekovic, G.J., *The ABCs of Behavior* presentation, September 2003.

WEBSITES:

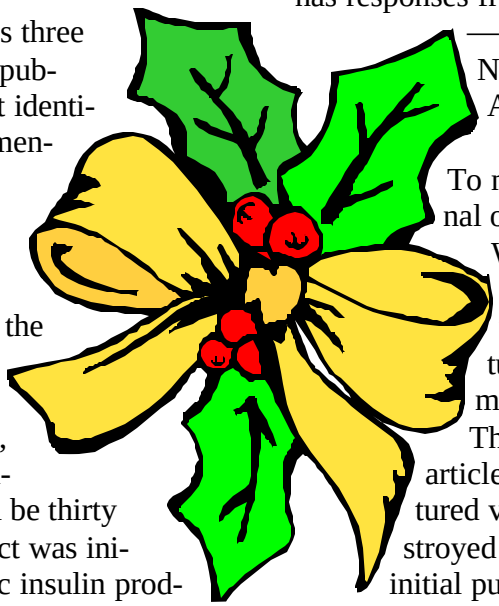
www.brazelon.org
www.laws.lp.findlaw.com

New Insulin Expiration Date Guidelines

By Mary Lewton, RN

The guidelines for the length of time insulin is effective for use in managing diabetes have undergone recent changes. Previous usage recommendations were to destroy any unused insulin following the manufacture expiration date on the insulin vial. The Internet had up-to-date information about storage of insulin with many recently published articles on the subject.

Although the first reference is three years old and is a newsletter published by a large pharmacy, it identifies the history of the recommendations. In an August 2000 newsletter by HealthCare Pharmacy to their constituents, HealthCare Pharmacy identified new guidelines for the storage of insulin. HealthCare Pharmacy suggested, regardless of product storage, "For Lilly brand insulin products, the expiration date shall be thirty days from the time the product was initially used. For Nova-Nordisc insulin products, the expiration date shall be six months from the time the product was initially used." (1)



The American Diabetes Association Inc. published a position statement in Diabetes Care 2003 that states: "Specific storage guidelines provided by the manufacturer should be followed. . . Although an expiration date is stamped on each vial of insulin, a loss in potency may occur after the bottle has been in use for > 1 month, especially if it was stored at room temperature." (2)

Another article in Diabetes Care 2003 written by Grajower, et el, is interesting because Dr. Grajower gives examples of two diabetic patients responses using Lantus insulin. Dr. Grajower monitored daily fasting blood sugars during the first 15 days and second 15 days when the same vial of Lantus insulin was utilized. The results showed a marked increase in fasting blood sugars during the second 15 days using the Lantus insulin. Grajower also has responses from the major pharmaceuticals — Aventis, Eli Lilly, Novo Nordisk —American Diabetic Association. (3)

To make things easier, The Journal of the Pharmacy Society of Wisconsin 2002 has compiled storage and stability information from insulin manufactures and the most current medical literature available. This is well worth copying. The article identifies that a seal punctured vial of insulin should be destroyed either 28 to 30 days after the initial puncture has been made. This article also includes information about the storage and usage of predrawn insulin and insulin pens. (4)

Website References:

- www.hcpharmacy.com/news/2000_08_05 f. html
- http://care.diabetesjournals.org/cgi/content /full/26/suppl_1/s121
- http://care.diabetesjournals.org/cgi/content /full/26/9/2665
- www.pswi.org

RAI Update

By Patricia Rotenberger, State RAI Coordinator

The RAI manual was revised in August 2003. All of the revisions have an impact on the staff in your facility who are completing the MDS and the care plan.

The first revision is for Section V and can be found on page 1-12. "If a care plan is written for a non-triggered RAP, it should be noted on the RAP summary form."

There are new tables on pages 2-5 through 2-33 that clearly define the timing for the required assessments.

On page 2-7 additional language was added to the significant change definition — "or by implementing standard disease-related clinical interventions."

Chapter 3 has several clarifications. Under Section H3i ostomies, do not code gastrostomies or other feeding ostomies here. Under H3a a scheduled toileting plan has three key elements — scheduled, toileting and program. A program is a specific approach that is organized, planned, documented, monitored and evaluated. Be sure to have all of these components in place before you can code scheduled toileting plan for a resident.

For a newly diagnosed UTI (urinary tract infection) identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code I2j, as long as the urine culture has been done and you are waiting for results. This information can be found on page 3-136.

Section M skin condition has been revised. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor. Continue to use reverse staging for coding pressure ulcers. This information is on page 3-161 & 3-162.

In order to code M5 Skin Treatments for a turning/repositioning program, a specific approach must be developed that is organized, planned, documented, monitored and evaluated. See page 3-167.

In Section P1b Therapies d. respiratory therapy "assessing breath sounds" has been added to the treatments provided by a qualified professional. See page 3-185.

If you have any questions about these revisions, please contact Pat Rotenberger, state RAI coordinator, at 328.2364.

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